

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014992

STATE FILE NUMBER
2 4282
Registrar's No.

FILED MAY 14 1959

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2720 S. 7th.		d. STREET ADDRESS 2720 S. 7th.	
3. NAME OF DECEASED (Type or print) First ALICE Middle MODINE Last GEE		4. DATE OF DEATH Month April Day 29, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-1910
9. AGE (In years at birthday) 48		10. USUAL OCCUPATION (Give kind of work done during most of working months, even if retired) Housewife	
11. BIRTHPLACE (City and state or country) Memphis, Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Frank Taylor		13b. MOTHER'S MAIDEN NAME Ollie Bracher	
14. NAME OF HUSBAND OR WIFE Aubrey Gee		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT J.E. Gee, 7211 Granston Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>443X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a)) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Death occurred at <u>Feb 16, 1959</u> <u>5:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		21. I attended the deceased from <u>4/29/59</u> and last saw her alive on <u>4/29/59</u>	
22a. SIGNATURE <u>Carol Hendon M.D.</u> (Degree or title)		22b. ADDRESS <u>1410 So 12th St.</u>	
22c. DATE SIGNED <u>4/30/59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>5/2/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Malden Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Malden, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>McLAUGHLIN'S, 2301 Lafayette Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 1 '59</u>	
26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D., C.P.</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed

H. G. Farris

Licensed Embalmer No. *3384*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.